BRIEF

SUPPORTING READINESS

Ensuring Excellent PTSD and Depression Care for Service Members

Posttraumatic stress disorder (PTSD) and depression are common and treatable psychological health concerns. Without appropriate treatment, these diagnoses can have a significant impact on service members and their families—yet little is known about the quality of care the Military Health System (MHS) provides for these conditions.

To help discover answers, the RAND Corporation is conducting perhaps the largest, most comprehensive independent look to date at how the MHS treats service members with PTSD and depression through a research initiative supported by the Department of Defense. The study marks an important step toward improving psychological health care for service members.

RAND CORPORATION

Service members with PTSD or depression need excellent care to meet their complex needs

Service members with PTSD or depression receive an abundance of medical care. The median number of outpatient visits for any reason is 41 per year for PTSD patients, and 30 visits per year for depression patients. Service members with PTSD or depression are seen by many different providers; the median number of unique providers during the study year was 14 for patients with PTSD, and 12 for those with depression. These service members frequently had other psychological health concerns, such as sleep and anxiety disorders. Five out of six service members received at least one psychotropic medication, and 45 percent of patients with PTSD and 31 percent of patients with depression received four or more medications. Excellent care is appropriate, timely, and coordinated. Given this combination of care utilization, number of different providers, and co-occurring diagnoses, ensuring coordination of care for these service members is extremely important.

The MHS shows important strengths, but improvements in care for PTSD and depression are needed

RAND results suggest that the MHS is a leader in providing timely outpatient follow-up after a psychiatric hospitalization. Eighty-six percent of patients with PTSD or depression received an outpatient visit within seven days of discharge. The period after a patient is discharged can be a vulnerable time, and such follow-up visits are critically important for these patients. Further, the vast majority of patients with a diagnosis received at least one psychotherapy visit—about 91 percent for those with PTSD and 82 percent for those with depression. This suggests that military patients who receive a diagnosis of PTSD or depression have access to at least some psychological health care.

But there are also areas where improvement is needed. Although most patients received at least one psychotherapy visit, the number and timing of visits may be inadequate to allow delivery of evidence-based psychotherapy. For example, patients newly diagnosed with either PTSD or depression should receive at least four psychotherapy or two medication management visits in the eight weeks following their diagnosis. Yet only one-third (34%) of patients newly diagnosed with PTSD and under a quarter of those with depression (24%) met this threshold. Further, only 45% of patients with PTSD and 42% with depression received a follow-up visit within 30 days of starting a new medication treatment. Patients need timely medication follow-up visits to adjust treatment, and these visits are particularly important when patients receive multiple medications.

The MHS shows areas of excellence . . .

86%

of patients with PTSD or depression received an outpatient visit within seven days of discharge from a psychiatric hospitalization.

91%

of patients with PTSD and 82% of patients with depression received at least one psychotherapy visit.

. . . and areas needing improvement.

Only 34%

of patients newly diagnosed with PTSD received minimally appropriate care in the 8 weeks following their diagnosis (at least four psychotherapy visits or two medication management visits). Only 24% of those with depression met this threshold.

Only 45%

of patients with PTSD and only 42% with depression received a follow-up visit within 30 days of starting a new medication treatment.

We are fortunate to be part of a system that celebrates its successes, and also directly confronts those areas that need greater attention.

—JONATHAN WOODSON, MD,
Assistant Secretary of Defense for Health Affairs in a January 5th, 2016, memo on The Military Health System as a High Reliability Organization

RAND's Approach

The study reviewed Military Health System administrative health care data for 14,576 active-duty service members who had a diagnosis of PTSD and 30,541 who had a diagnosis of depression in the first six months of 2012. RAND followed their care for a year after their diagnosis to assess whether those service members were receiving evidence-based care and whether there were any disparities in care quality by branch of service, geographic region, or service member characteristics.

Service members with PTSD or depression receive considerable medical care, so providing excellent care is critical.

41
visits per year
median number of outpatient visits for any reason for PTSD patients

30
visits per year
median number of outpatient visits for any reason for depression patients

5 of 6
received psychotropic medication

14
unique providers
median number of unique providers per patient with PTSD

12
unique providers
median number of unique providers per patient with depression

Quality of care for PTSD and depression varies by service branch, region, and service member demographics

However, no branch or region consistently outperformed or underperformed relative to the others. We also found no consistent patterns of variation in the quality of care by patient characteristics (age, gender, pay grade, race/ethnicity, or deployment history). Nonetheless, these variations indicate that the MHS can improve by providing excellent care consistently.

We owe it to service members to ensure that they receive excellent mental health care regardless of where they serve, where they live, or who they are. The Department of Defense has shown leadership in supporting such a comprehensive assessment of care for PTSD and depression. Transparent assessments of care delivered are essential to ensuring excellent care for all service members and their families.

—KIMBERLY A. HEPNER, PhD,
lead author, senior behavioral scientist and licensed clinical psychologist

THIS BRIEF describes work done in the RAND National Defense Research Institute and documented in *Quality of Care for PTSD and Depression in the Military Health System: Phase 1 Report*, by Kimberly A. Hepner, Elizabeth M. Sloss, Carol P. Roth, Heather Krull, Susan M. Paddock, Shaela Moen, Martha J. Timmer, and Harold Alan Pincus, RR-978-OSD (available at www.rand.org/t/RR978), 2016.
To view this brief online, visit www.rand.org/t/RB9876.

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The DoD is positioned to be a leader in providing high-quality, evidence-based care for PTSD and depression.

Recommendations

RAND recommends the DoD take the following steps to implement strategies that improve the quality of care for psychological health conditions delivered by the Military Health System.

1

Establish an enterprise-wide system that includes high-priority quality measures to assess care for psychological health conditions. A separate system for psychological health is not required; psychological health quality measurement could be integrated into an enterprise-wide system that assesses care across medical and psychiatric conditions.

2

Increase transparency—which provides key information to guide improving care—by reporting the results of quality measures for PTSD, depression, and psychological health both internally and publicly. The MHS has recently increased public reporting of quality measure rates (www.health.mil and www.tricare.mil), yet currently only two measures are related to psychological health (outpatient follow-up after psychiatric hospitalization within seven and 30 days after discharge).

3

Investigate the reasons for variations in care for PTSD and depression. Understanding what factors lead to higher and lower performance can guide quality improvement initiatives. For example, specific policies or practices adopted by a single service branch may prove useful to adopt enterprise-wide.